DEPARTMENT OF HEALTH AND HUMAN SERVICES
HEALTH CARE FINANCING ADMINISTRATION

FORM APPROVED
OMB NO. 0938-0193

TRANSMITTAL AND NOTICE OF APPROVAL OF STATE PLAN MATERIAL

FOR: HEALTH CARE FINANCING ADMINISTRATION

1. TRANSMITTAL NUMBER: **2002-17**

2. STATE: **MS**

3. PROGRAM IDENTIFICATION: TITLE XIX OF THE SOCIAL SECURITY ACT (MEDICAID)

TO: REGIONAL ADMINISTRATOR
HEALTH CARE FINANCING ADMINISTRATION
DEPARTMENT OF HEALTH AND HUMAN SERVICES

4. PROPOSED EFFECTIVE DATE
October 1, 2002

5. TYPE OF PLAN MATERIAL *(Check One)*:

☐ NEW STATE PLAN ☐ AMENDMENT TO BE CONSIDERED AS NEW PLAN ☒ AMENDMENT

COMPLETE BLOCKS 6 THRU 10 IF THIS IS AN AMENDMENT *(Separate Transmittal for each amendment)*

6. FEDERAL STATUTE/REGULATION CITATION:
Section 1932(a) of the Social Security Act

7. FEDERAL BUDGET IMPACT:
a. **FFY 2003** **$ 185,229,753**
b. **FFY 2004** **$ 180,000,000**

8. PAGE NUMBER OF THE PLAN SECTION OR ATTACHMENT:
Section 1.6, Pages 1a, 1b, 1c and 1d, 1e
Pen + Ink change added per your email from Rose Compere dtd 10.2.02

9. PAGE NUMBER OF THE SUPERSEDED PLAN SECTION OR ATTACHMENT *(If Applicable)*:
Section 1.6, Pages 1a, 1b, 1c and 1d, 1e
Pen + Ink change added per email from Rose Compere dtd 10.2.

10. SUBJECT OF AMENDMENT: This State Plan Amendment is being filed to allow the Division of Medicaid to develop a program for women of child bearing age and infants 1 and under to primarily cover obstetrical care associated with low birth weight and pre-term babies.

11. GOVERNOR'S REVIEW *(Check One)*:
☒ GOVERNOR'S OFFICE REPORTED NO COMMENT
☐ COMMENTS OF GOVERNOR'S OFFICE ENCLOSED
☐ NO REPLY RECEIVED WITHIN 45 DAYS OF SUBMITTAL
☐ OTHER, AS SPECIFIED:

12. SIGNATURE OF STATE AGENCY OFFICIAL:
Sharon Y. Reed for RLP

13. TYPED NAME: **Rica Lewis-Payton**

14. TITLE: **Executive Director**

15. DATE SUBMITTED: **August 14, 2002**

16. RETURN TO:
Rica Lewis-Payton, Executive Director
Miss. Division of Medicaid
Attn: Rose Compere
239 North Lamar Street, Suite 801
Jackson, MS 39201

FOR REGIONAL OFFICE USE ONLY

17. DATE RECEIVED
August 15, 2002

18. DATE APPROVED
October 1, 2002

PLAN APPROVED - ONE COPY ATTACHED

19. EFFECTIVE DATE OF APPROVED MATERIAL
October 1, 2002

20. SIGNATURE OF REGIONAL OFFICIAL
/s/ Richard P. Kusserow, Regional Administrator

21. TYPED NAME

22. TITLE

23. REMARKS
Pen and Ink changes made to Item 8 and Item 9 to add Page 1e per email from Rose Compere dated 10/2/02

FORM HCFA-179 (07-92)

Section 1932 A(1) State Option to Use Managed Care - Population Health Management Program

Citation
Section 1932 of
the Social Security Act

Maternity care provided to Medicaid beneficiaries is provided through the provisions of Section 1932(a) of the Social Security Act enacted through provisions of the Balanced Budget Act of 1997. Population Health Management Program will provide services for pregnant women and infants under one year of age. This program is primarily for inpatient and outpatient obstetrical care associated with low birth-weight and pre-term babies. The Population Health Management Program will operate on a statewide basis, through the state's public health districts that are currently recognized by the State Public Health Department. The state contracts with entities who have arrangements with health care professionals to provide case management related services to pregnant women and infants one year and under who are in the program.

I. Assurances

A. All requirements will be met for 1932 and 1905(t) of the Social Security act. There will be public involvement in the design and implementation of the program. Public comments and involvement will be solicited on an on-going basis through surveys, focus groups and other means.

B. The following categories of Beneficiaries are not eligible to enroll in the Plan:

(1) Beneficiaries who are, at the time of application for enrollment or at the time of enrollment, domiciled or residing in an institution, including nursing facilities, hospital swing bed units, intermediate care facilities for the mentally retarded, mental institutions, psychiatric residential treatment facilities, or correctional institutions;

(2) Beneficiaries enrolled in Home and Community-Based (HCBS) Waiver programs. HCBS beneficiaries can dis-enroll from the HCBS program and can choose to enroll.

(3) Disabled workers at 200% poverty level;
(4) Individuals who meet the eligibility requirements for receipt of both Medicaid and Medicare benefits.
(5) Indians who are members of Federally-recognized tribes;
(6) Children under 19 years of age who are:
  (1) eligible for SSI under Title XVI except children under one of low birthweight (< 2500 grams).
  (2) described in Section 1902(e)(3) of the Social Security Act;
  (3) in foster care or other out-of-home placement;
  (4) receiving foster care or adoption assistance; or
  (5) receiving services through a family-centered, community-based, coordinated care system receiving grant funds under Section 501(a)(1)(D) of Title V.

C. Each Public Health Region will have one entity known as the Population Health Management Contractor responsible for the Population Health Management Program in that region. These public health regions will be comprised of public health districts as follows:

Region I - Districts 1, 2 and 3
Region II - Districts 4, 5 and 6
Region III - Districts 7, 8 and 9

Each pregnant beneficiary will be enrolled in the PHM in the county of her residence. Individuals will have a choice of at least two (2) delivering health care professionals from within the system. Population Health Management Contractor (PHMC) must ensure that each beneficiary has the ability to choose among delivering health care professionals enrolled in the entity.

4. Beneficiaries will be permitted to change delivering health care professionals at any time for cause and without cause once in the first 90 days beginning on the date the beneficiary receives official notification of enrollment and at least 12 months after enrollment with the entity. Beneficiaries may elect to change providers within the system but may not elect to dis-enroll from the Population Health Management Program (PHM). Beneficiaries who refuse to enroll or follow program guidelines will be responsible for payment of services provided.

E. **Default Enrollment Process**
Default enrollment by the PHMC in a PHM Program area will be through equivalent distribution among delivering health care professionals who are enrolled in the Maternity Program and have the capacity to serve additional beneficiaries. At program implementation and 30 days post implementation, PHM Contractors are required to offer participation to qualified delivering Health Care Professionals who agree to participation requirements. Afterwards the PHMC will offer open enrollment annually. The state has established a policy that each provider meets required qualifications to participate as a program provider. Beneficiaries will be required to select a provider or be assigned to one within two weeks after contractor's notification.

F. Information will be provided to beneficiaries on the PHMC, enrollee rights and responsibilities, grievance and appeal procedures, covered items and services, benefits not covered through the Population Health Management Program, cost sharing, service areas and quality performance to the extent available. This information will be provided to all Medicaid eligible women of childbearing age and infants under one year of age upon implementation of the program. Additionally, this information will be updated if PHMC(s) change. This information will be available on an ongoing basis in key places within the state such as physician's offices, clinics, and local Department of Human Services. Medicaid will retain approval authority for all marketing materials.

II The number of Population Health Management Contractors will be restricted to one in each of the public health regions within the state. The State will assure that the contractor provider network is adequate and available during procurement of Population Health Management Contractors for each region. Assurance of access to care is accomplished through review of the number of beneficiaries and delivering health care professionals within each district and county. Consideration will be given to the number of providers that practice in the county, travel times, national standards such as published by the American College of Obstetrics and Gynecology and other factors that may be present in the health care infrastructure in the area. The PHMC will be required to continuously monitor access to care to ensure that standards are met on an ongoing basis. Monitoring is

also accomplished through the grievance process. Medicaid will monitor the PHMC annually through the administrative review process to ensure access to care is available. Public Health districts are based on county designation and consist of one or more counties per district.

III. Population Health Management Contractors will be selected through evaluation of the contractor's ability to provide required components of the Population Health Management Program. These include, but are not limited to, private entities, non-profit corporations, Provider Service Organizations, Health Departments, or similar entities that meet Population Health Management Contractor Qualifications. Assurance is provided that Population Health Management Contractor contracts will contain, at a minimum, terms required under Sections 1932 and 1905 (t) (3) of the Social Security Act.

Contracts with such entities require:

A. PHM Contractors will provide reasonable and adequate hours of operation, including 24 hour 7 day availability of information referral and treatment with respect to medical emergencies;

B. The PHM Contractors will enroll only those individuals residing sufficiently near a service delivery site to be able to reach that site within a reasonable time using available and affordable means of transportation;

C. The PHM Contractors will provide for arrangements with or referrals to a sufficient number of physicians and other appropriate health care professionals to ensure that services under the contract will be delivered promptly and without compromising quality of care;

D. The PHM Contractors will not discriminate on the basis of health status or requirements for health care services in enrolling, disenrolling or re-enrolling Medicaid beneficiaries;

E. The PHM Contractors will permit individuals to change delivering health care professionals in accordance with the provisions in Section 1932 (a) (4); and

F. The PHM Contractors will comply with other applicable provisions of Section 1932, including requirements and provisions of marketing.

G. The state assures that the contract with Population Health Management Contractors meets all the terms required under Section 1905(t)(3). Reimbursement for the contractors will be based on a global rate determined by the cost reports.